Understanding Traditional and Other Culture-Based Approaches to Mental Illness in Lower and Middle Income Contexts

Joseph D. Calabrese*

To be published in *The Routledge Handbook of International Development, Mental Health and Wellbeing*, edited by Laura Davidson (Routledge Press)

Introduction

Those working to improve the treatment of mental illness in diverse cultural contexts often deal with a complex landscape of religious interpretations of illness, ritual interventions, alternative systems of plant medicines, and various claims of efficacy.[1] These voices and claims must be balanced with a commitment to actually enhancing well-being, in line with UN Sustainable Development Goal 3 (SDG3) to "ensure healthy lives and promote well-being for all at all ages." Evaluating each context independently is crucial, as some alternatives to 'Western' medicalised interventions enhance patient health, whilst others impede it or even cause harm. In attempting to illuminate this landscape, this chapter will draw on the author's decades of experience as a medical anthropologist and clinical psychologist researching mental illness and its treatment, whilst also personally treating patients in several different societies. Case examples will be drawn primarily from fieldwork and clinical practice in Native North American communities and in Bhutan.

It is a familiar refrain for many medical anthropologists that health care must be delivered in a manner that is culturally appropriate and that existing therapeutic traditions must be respected, thus avoiding cultural imperialism. In line with this sentiment, the World Health Organization (WHO) has encouraged the use of traditional medicine and its

* Joseph D. Calabrese is a Chartered Psychologist and Reader of Medical Anthropology, Department of Anthropology, University College London, and a prior Visiting Professor, University of Medical Sciences of Bhutan, Thimphu, Bhutan.

[1] For an example in the Ugandan context, see Davidson L., Liebling H., Akello, G. F. & Ochola, G. (2016), The experiences of survivors and trauma counselling service providers in northern Uganda: Implications for mental health policy and legislation, *International Journal of Law and Psychiatry*, 49, Part A, Nov-Dec, pp.84-92, at p.86.

integration into health systems.[2] There are significant potential benefits attached to this strategy, especially the fact that integration may facilitate clinical evaluation of traditional treatments, oversight of practitioners (some of whom have been known to chain or beat patients, or restrict food),[3] and minimisation of risks (such as organ damage from the use of toxic herbs or potions, or wound sepsis from chaining), all of which are imperative.[4] However, such a blanket policy tends to de-emphasise the particularities of local contexts, the problems being addressed, and the nature of the medicines and procedures involved. Worse, it may give the appearance of having more to do with economic limitations, including the lack of trained personnel, or indeed, with political correctness, than with a desire to undertake serious research and improve contexts of care. This top-down approach has been critiqued in some WHO studies, such as those that compare the course of psychotic disorders in 'developing' versus 'developed' countries - a dichotomy that tends to reduce complex inter-societal variations to economics - when a careful study of local factors at particular sites would have been much more illuminating.[5] Supporting traditional treatments makes sense when the local interventions can be shown to be effective, or at least beneficial to society, and are not harmful. In other cases, traditional understandings (such as those that attribute severe mental illness to sin or to a spiritual entity) can simply impede and delay effective healthcare delivery.

When reviewing ethnographic research on traditional health care approaches, certain things become clear. Sociocultural constructions of illness relate to local understandings of the person and cosmology, which tend to be embedded in spiritual frameworks. Aetiological understandings are often personalistic, finding the cause of illness in the actions of a witch, an angry deity, or a spirit who has possessed the person's body or captured their soul.[6]

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[2] World Health Organization (2013), *WHO Traditional Medicine Strategy 2014-2023*. Available at: www.who.int/medicines/publications/traditional/trm_strategy14_23/en. [Last accessed 16 February 2017.]

[3] For example, see Sorketti, E. A., Zainal, N. Z. & Habil, M. H. (2013), The treatment outcome of psychotic disorders by traditional healers in central Sudan, *International Journal of Social Psychiatry*, 59, pp.365-376; Adelekan, M. L., Makanjuola, A. B. & Ndom, R. J. E. (2001), Traditional Mental Health Practitioners in Kwara State, Nigeria, *East African Medical Journal*, 78(4), pp.190-196.

[4] The risks associated with chaining were also made apparent when 28 patients of a faith-based mental asylum in Erwadi, Tamil Nadu, died in a fire, unable to escape due to their chains. See Krishnakumar, A. (2001), Escape from Erwadi, *Frontline*, 18(18), September 1-14, http://www.frontline.in/static/html/fl1818/18180270.htm. [Last accessed 2 April 2017.]

[5] Calabrese, J. D. & Corrigan, P. W. (2005), 'Beyond Dementia Praecox: Findings from Long-Term Follow-up Studies of Schizophrenia', in R. Ralph & P. Corrigan (eds.), *Recovery in Mental Illness: Broadening Our Understanding of Wellness* (Washington, DC: American Psychological Association). See also Cohen, A., Patel, V., Thara, R., & Gureje, O. (2008), Questioning an Axiom: Better Prognosis for Schizophrenia in the Developing World?, *Schizophrenia Bulletin*, 34(2), pp.229-244.

[6] Foster, G. M. (1976), Disease Etiologies in Non-Western Medical Systems, *American Anthropologist*, 78(4), pp.773-782.

Illness may also be understood in terms of sin, spiritual pollution or an imbalance of humours. It is crucial to understand that when these understandings of illness are present, therapeutic intervention will address these postulated causes, taking the form of witch detection/nullification, ritual exorcisms, shamanic spirit flights to retrieve the soul, prayer, or various forms of purification or re-balancing of humours.[7] Traditional healing approaches thus may relate more to postulated - but evidentially unsupportable - religious entities, rather than to the actual causes of illness.

The confusion of illness with religious phenomena, although fascinating anthropologically, can lead to tragedies and atrocities. For example, in 2015 in Nepal, Kodai Harijan consulted a local shaman, seeking help for his sick son. The diagnosis was spirit possession. The shaman told Harijan that his son could be cured, but that it would require a human sacrifice. According to testimony given to police, Harijan and his relatives found the ten-year-old boy Jivan Kohar playing with friends in the village and lured him away with a packet of biscuits and the promise of 50 rupees (around thirty pence). The boy was taken to a temple on the outskirts of the village where the shaman performed a religious ritual. The boy was then taken to a field nearby, where three people held him down as Hirijan slit his throat with a sickle. When police found him, the boy's head had almost been severed from his body.[8] In another case, described in detail by Fadiman,[9] a three-month-old Hmong girl, Lia Lee, began experiencing epileptic seizures, which her parents understood as a spiritual condition involving her soul being 'caught' by a spirit. The Lees worried about their child's health, but also considered the illness to be a positive sign that she may have spiritual gifts. Lia's doctors changed her anticonvulsant medication over twenty times in an effort to control her seizures. They could not determine whether Lia was convulsing despite her drugs, or because she was no longer receiving them. Confused by the doctor's regimen of drugs that seemed to make Lia worse, the parents had reduced Lia's anticonvulsant drugs and employed their own traditional remedies, including herbal medicines, massage, and treatment by a

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[7] Knauft, B. M. (1985), *Good Company and Violence: Sorcery and Social Action in a Lowland New Guinea Society* (Berkeley: University of California Press); Herdt, G. (1990), 'Sambia Nosebleeding Rites and Male Proximity to Women', in J. W. Stigler, R. A. Shweder, & G. Herdt (eds.) (1997), *Cultural Psychology: Essays in Comparative Human Development* (Cambridge: Cambridge University Press), at pp.366-400; A. Fadiman (1997), *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (New York: Farrar, Straus & Giroux).

[8] Dunn, J. (2015), 'Desperate father kidnapped and murdered a ten-year-old boy in religious ritual after a holy man told him a human sacrifice would save his ailing son in Nepal', Daily Mail, 27 July 2015. http://www.dailymail.co.uk/news/article-3176306/Desperate-father-kidnapped-murdered-ten-year-old-boy-religious-ritual-holy-man-told-human-sacrifice-save-ailing-son-Nepal.html#ixzz4YtmjXWpy. [Last accessed 17 February 2017.]

[9] Fadiman (1997), *op cit.*, nt.7.

Hmong shaman. If a drug seemed to make her better, they increased the dose. Lia eventually had a massive seizure that left her brain-dead.

Plant medicines, often assumed to be harmless because they are 'natural' or because they have been used for generations, can also cause harm. It cannot be assumed that 'natural' means safe. Lead, mercury and arsenic are natural, but are also potent poisons,[10] and according to a study published by the Centers for Disease Control and Prevention[11] these substances can be found in various Ayurvedic medicines.[12] An interesting table is included in the study listing various medicines with trustworthy sounding manufacturers such as 'Vyas Pharmaceuticals' or 'Research Drugs & Pharmaceuticals' - yet, they were found to have concentrations of mercury as high as 10%, of arsenic as high as 5.2%, and of lead as high as 4.7%. In the early 1990s in Brussels, around 100 otherwise healthy young women started presenting with advanced kidney disease that would ultimately require dialysis or renal transplantation.[13] An investigation revealed that they had all attended the same weight-loss programme which gave them *Aristolochia*, a Chinese herb used for millennia. It was found to cause both irreversible kidney damage and cancer. There may be many other commonly used traditional medicines which are toxic and, obviously, additional scientific studies are required before their use is encouraged.

The situation is complicated further by the fact that reports of therapeutic improvement by patients may be inaccurate. In their study of the outcomes of patients seeing a particular Taiwanese traditional healer, Kleinman and Sung demonstrate that efficacy cannot be established based on patients' self-reports.[14] As the authors point out, most

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[10] According to the WHO, "[m]ercury is a naturally occurring element that is found in air, water and soil… Exposure to mercury – even small amounts – may cause serious health problems, and is a threat to the development of the child in utero and early in life" (see WHO (2017) 'Mercury and Health Fact Sheet'. Available at: http://www.who.int/mediacentre/factsheets/fs361/en/. [Last accessed 29 May 2017.] The WHO also states that "[l]ead is a cumulative toxicant that affects multiple body systems and is particularly harmful to young children…. There is no known level of lead exposure that is considered safe" (see WHO (2016) 'Lead Poisoning and Health Fact sheet', http://www.who.int/mediacentre/factsheets/fs379/en/. [Last accessed 29 May 2017.]

[11] Hore, P., Ahmed, M., Ehrlich, J., *et al* (2012), Lead poisoning in pregnant women who used ayurvedic medications from India - New York City, 2011-2012, *Morbidity and Mortality Weekly Report* (Centers for Disease Control and Prevention), 61, pp.641-646. Available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6133a1.htm. [Last accessed 18 February 2017.]

[12] Ayurveda is an ancient medical system that originated in India. Ayurvedic medicines may include herbs, minerals, metals or other materials, some of which are known to be toxic. However, in the US these medicines are regulated as dietary supplements and thus are not required to meet safety and effectiveness standards required of conventional medicines.

[13] Grollman, A. P. & Marcus, D. M. (2016), Global Hazards of Herbal Remedies: Lessons from Aristolochia, *EMBO Reports*, 17(5), pp. 618-26.

[14] Kleinman, A. & Sung, L. H. (1979), Why do Indigenous Practitioners Successfully Heal?, *Social Science and Medicine*, 13B, pp.7-26.

efficacy studies in anthropology do not carry out later follow-ups, but rely on reports soon after ritual treatment. This is problematic because patients may be constrained by cultural norms to discuss ritual outcomes in exclusively positive terms. In their follow-up study of twelve patients treated by a ritual healer, Kleinman and Sung found that ten people rated themselves at least partially cured. However, they write that this occurred despite the lack of any significant symptom change in several cases, and in the face of "considerably worsened symptoms in one case."[15]

As these examples make clear, ritual treatments and traditional medicines can be ineffective or even deadly, even when believed by the local population - and reported by specific patients - to be effective. Traditional practices and other culture-based approaches, such as attempted healings in evangelical churches, typically target a different metaphysical domain and view of the body than that which can be demonstrated empirically. This especially tends to be the case when dealing with mental illnesses. However, traditional approaches sometimes discover and perpetuate a therapeutic methodology, even though the local supernatural rationalisation of the procedures clashes with science-based understandings of the therapeutic. As is described in the following case study from the author's work with Native Americans, there may be unacknowledged therapeutic processes at work that can nevertheless be analysed, and which result in measurable therapeutic outcomes.

Native American ritual peyote use

Native North American communities can be considered internal colonies of the United States and they face similar problems to lower and middle income countries (LMICs), such as health disparities, poverty, war-related historical trauma, environmental risks, racism, healing systems that conflict with scientific biomedicine, and a significant burden of mental illness. Thus, the focus of this chapter encompasses lower and middle income *contexts* rather than countries. By one calculation, as many as one hundred million indigenous people died as a result of the European colonisation of the Americas, which constitutes a genocide.[16] Today, according to government statistics, over one in four Native Americans live in poverty.[17] In

[15] *Ibid*, p.7.
[16] Stannard, D. E. (1992), *American Holocaust: Columbus and the Conquest of the New World* (New York: Oxford University Press).
[17] US Census Bureau (2015), *American Community Survey 1-Year Estimates*. Available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk. [Last accessed 19 February 2017.]

terms of health disparities, in 2014 Native American deaths from alcoholism were 520% greater than the 2008 US average, deaths from tuberculosis were 450% greater, deaths from chronic liver disease and cirrhosis were 368% greater, deaths from diabetes mellitus were 177% greater, and suicide rates for Native American youth were over three times the national average.[18]

During two years of anthropological fieldwork living amongst the Navajos of the Southwestern United States, the author was immersed in a context disrupted by genocidal colonialism and came to focus on a post-colonial healing tradition called the Native American Church (NAC).[19] The NAC is a ritual-based healing tradition within many Native North American tribes that addresses alcoholism and other mental health issues. The tradition has been subject to attacks by the US government as well as tribal governments,[20] given its therapeutic use of peyote, a psychedelic cactus used by Native Americans for six millennia, within a symbolically structured ritual process. Fieldwork in Navajo communities was combined with a year-long clinical psychology placement treating adolescent patients at a Navajo treatment programme. This programme incorporated traditional healing rituals into the treatment process in response to the local demand for culturally appropriate health care.[21]

The project came about in response to legal attacks on NAC members, motivated by the 'War on Drugs', and specifically the case of *Oregon v. Smith*.[22] The US Supreme Court decided that followers of the NAC, which was previously protected by the Free Exercise Clause,[23] could now be found guilty of a class B felony. The research revealed that it was standard practice at the federally-funded clinical facility at which the author treated Native American adolescents to include Peyote Ceremonies in treatment and aftercare plans (when approved by their parents). In fact, the US government reimbursed practitioners of the

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[18] Indian Health Service (2014), Trends in Indian Health. Available at: https://www.ihs.gov/dps/includes/themes/newihstheme/display_objects/documents/Trends2014Book508.pdf. [Last accessed 17 February 2017.]; Surgeon General of the US Public Health Service (2005), 'Statement on Suicide Prevention among Native American Youth before the Indian Affairs Committee, US Senate'. Available at: www.hhs.gov/asl/testify/t050615.html.

[19] Calabrese, J. D. (2013), *A Different Medicine: Postcolonial Healing in the Native American Church* (New York: Oxford University Press).

[20] O. C. Stewart (1987), *Peyote Religion: A History* (Norman: University of Oklahoma Press), pp.128-147, pp.203-208, and pp.296-310.

[21] Complete findings are reported in Calabrese (2013), *op cit*, nt.19.

[22] *Employment Division of Oregon v. Smith*, 494 US 872 (1990). Also see Calabrese, J. D. (2001), The Supreme Court versus Peyote: Consciousness Alteration, Cultural Psychiatry and the Dilemma of Contemporary Subcultures, *Anthropology of Consciousness*, 12(2), pp.4-19.

[23] The Free Exercise Clause of the First Amendment of the US Constitution specifies that Congress shall make no law prohibiting the free exercise of religion.

ceremony for clinical services.[24] The research indicated that addictive behaviours were often changed and well-being enhanced due to participation in the Peyote Ceremony. An experience at a Peyote Ceremony, such as a symbolically structured vision, was often the catalyst for recovery mentioned in interviews, and continued participation operated as aftercare, providing a supportive community since alcohol use is viewed as a sin.[25]

To seek scientific clarity on these apparently positive outcomes, the author was involved in the setting up of an independent controlled study of mental health outcomes of NAC members through the Harvard Medical School.[26] The study, published in *Biological Psychiatry*, compared mental health and neuropsychological test results of a group of Navajos who regularly used peyote with a group reporting minimal use of peyote, alcohol or other substances, and another group of recovered alcoholics from the Navajo community. Results indicated that the former alcoholic group showed significant deficits on every scale of the Rand Mental Health Inventory (RMHI)[27] and on two neuropsychological measures.[28] However, the peyote group showed no significant differences from the abstinent comparison group on most scales, and scored significantly better on two scales of the RMHI. Furthermore, amongst NAC members, greater lifetime peyote use was associated with significantly better RMHI scores on five of the nine scales, including the composite Mental Health Index.

Although the Native American participants tend to explain these outcomes in spiritual terms, they can be analysed in terms of known and measurable communicative, social and psychological processes. This sort of analysis can illuminate processes that are often reduced to 'the placebo effect.' The therapeutic efficacy can be considered in terms of the symbolically structured ritual process, including the strategic use of the psychoactive medicine, as well as the broader cultural ontology that is built up as an experiential reality for participants. That ontology focuses on the individual's relationship with peyote, experienced as a conscious entity that can monitor one's thoughts and behaviours (and especially

[24] Calabrese (2013), *op cit.*, nt.19, pp.38-39. Also see S. J. Kunitz & J. E. Levy (1994), *Drinking Careers: A Twenty-Five Year Study of Three Navajo Populations* (New Haven: Yale University Press), p.202.
[25] Calabrese (2013), *ibid*, Chapter VI.
[26] Halpern, J. H., Sherwood, A. R., Hudson, J. I., *et al* (2005), Psychological and Cognitive Effects of Long-Term Peyote Use among Native Americans, *Biological Psychiatry*, 58, pp.624-631.
[27] The RMHI measures anxiety, depression, and other aspects of psychological distress and well-being. See Veit, C. T. & Ware, J. E. (1983), The structure of psychological distress and well-being in general populations, *Journal of Consulting and Clinical Psychology*, 51, pp.730-742.
[28] These neuropsychological measures were reported as the "immediate condition" of the Rey-Osterreith Complex Figure Test (it is assumed that the authors meant the "immediate recall" condition) and total perseverations on the Wisconsin Card Sort Test.

intervening to prevent or punish alcohol use), in addition to its status as a sacred medicinal substance.

Peyote is used in an all-night ritual that takes place in a tipi that opens to the east to face the rising sun. Inside, an altar of earth is made in the shape of a half moon. A line is sketched along the top, called 'the Road', which represents the path of one's life, beginning at birth on the left and rising to its highest potency in adulthood; then decreasing in potency as one approaches old age and death. Thus, the moon symbol functions, on one level, as a symbol of one's life, implying a process of critical self-reflection on one's life path during the ritual. At another level, the moon is a symbol of transformation because it is said that the moon changes by growing and shrinking once a month.[29] Navajos also view the moon as representative of the natural process of human gestation, as it takes nine moons (or months) to create life. Accordingly, in this one ritual symbol, the participant's life course is embedded symbolically within natural transformative processes. The multiple meanings of the moon symbol weave a plot involving the transformative re-gestation of the self. The tipi also plays a part in this gestation symbolism. Navajos explained that the tipi represents a pregnant female with a blanket facing east, and the beating of the peyote drum replicates the sound of a mother's heartbeat as heard from inside the womb.

The timing of the ritual is another component of the symbolic process. The ritual begins at nightfall, at the ending of one day, and moves the patient symbolically to the dawning of a new day, accompanied by many symbols of rebirth, renewal, and natural transformation. At dawn the participants emerge from the tipi and greet the new day in a symbolic rebirth from the maternal image of the tipi. The ingestion of the peyote cactus supports this narrative intervention not only through its ability to produce impressive visions (interpreted as divine communications), but also through its pharmacological ability to enhance suggestibility.[30] This quality was established in experimental studies undertaken at Stanford University by Sjoberg and Hollister in 1965 which found that mescaline, the main psychoactive ingredient of peyote, enhanced primary suggestibility to the level of a hypnotic

[29] Calabrese (2013), *op cit.*, nt.19, pp.124-136.
[30] Suggestibility as used here is the ability to have one's perceptions, cognitions and behaviours influenced by suggestions, such as hypnotic suggestions. Levels of suggestibility can be measured using various tests, such as the Stanford Suggestibility Scale.

induction.[31] Therefore the plant medicine is used to enhance the delivery of therapeutic messages, making them, in effect, post-hypnotic suggestions.

Even though peyote is itself a serotonergic substance,[32] this is, admittedly, a very different understanding of psychopharmacology than that found in Euro-American psychiatry, which often provides psychopharmacological intervention without much work being carried out on the patient's meaningful interpretation of the intervention. Modern clinical disciplines separate the pharmacological and meaning-related approaches into the disciplines of psychiatry and clinical psychology. This results in psychiatric medicines being administered in a technical manner, with little effort devoted to emplotting their use in a meaningful way.[33] In contrast, within Native American contexts that are not mind/body dualist in the same way, psychoactive plant medicines are used to transform self-awareness and enhance emplotment in a narrative. Psychopharmacological intervention to facilitate creative shifts in perspective, therapeutic emplotment, or insight is not the standard usage of psychiatric medicines in Euro-American psychiatry. The dominant agonist/antagonist (materialist) paradigm of Euro-American psychiatry focuses on fixing discrete neurochemical imbalances within a mechanistic medical model. The Peyote Ceremony represents an entirely different paradigm of psychopharmacological intervention focused on higher-order mental processes like experience, emotion, insight, creativity, and planning. It goes beyond the synapse and neurotransmitter to the levels of meaning, self-reflection, and social interaction. The author refers to this approach as a semiotic/reflexive paradigm of psychopharmacology, as opposed to the agonist/antagonist model of Euro-American psychiatry.[34]

This case study demonstrates that a particular local intervention can be extremely effective for a particular set of mental health issues, even though the approach clashes strongly with standard biomedical theories and practice and tends to be rationalised in spiritual terms. Perhaps an intervention with this depth of psychological impact is needed, given the history of trauma and radical disruption of Native American communities. The

[31] Sjoberg, B. M., & Hollister, L. E. (1965), The Effects of Psychotomimetic Drugs on Primary Suggestibility, *Psychopharmacologia*, 8, pp.251-262.

[32] Serotonin is a neurotransmitter. Serotonergic substances are substances that produce their effect by interacting with the serotonin system. For example, several antidepressant medications currently in use are serotonergic substances that have an effect by selectively inhibiting the reuptake of serotonin.

[33] Calabrese (2013), *op cit*, nt.19, pp.29-35. To 'emplot' something, as used here, means simply to place it into a story or narrative.

[34] *Ibid*, pp.25-6 and p.137. The existence of two very different paradigms of psychopharmacology creates a paradigm clash in which Euro-Americans perceive Native American peyote use not as part of a therapeutic intervention, but in an ethnocentric manner – *i.e.*, as substance misuse.

case foregrounds the importance of getting past centuries of ethnocentric dismissal (currently in the form of a 'War on Drugs') in order to recognise an alternative and viable system of psychopharmacological intervention, incorporating cognitive and social interventions with demonstrable therapeutic outcomes.[35] The proper ethical response is to support this indigenous intervention to treat the particular mental health issues for which it is effective.

Severe mental illness and public psychiatry in Bhutan

Bhutan is a Buddhist Kingdom in the eastern Himalayas wedged between China and India. It has an officially recognised population of around 750,000. Given various factors, not least its location across several high mountain valleys, Bhutan has remained very isolated for most of its history. The government permitted television and the internet only in 1999. Bhutan has become famous for its Gross National Happiness (GNH) policy,[36] which resonates with SDG3 and implies a critique of exclusively economic development goals. Bhutan measures happiness and well-being, seeking to improve them. The GNH Index incorporates subjective and objective indicators of well-being across nine domains: psychological well-being, health, education, cultural diversity and resilience, time use, good governance, community vitality, living standard, and ecological diversity and resilience. However, even in Bhutan there are people coping with mental illness who remain at special risk of unhappiness. A mental health system was launched in Bhutan very late in comparison with most other countries, with the Psychiatry unit at Jigme Dorji Wangchuck National Referral Hospital only opening in 1997. An inpatient psychiatry ward was opened in April 2004. There are only two psychiatrists and a few psychiatric nurses for the entire country.[37] There are no clinical psychologists and very

[35] The findings of this research have been used by the National Health Service Corps (a part of the US Department of Health and Human Services) to train health professionals to provide culturally competent primary health care services to under-served populations. See R. T. Trotter (1999), *National Health Service Corps Educational Program for Clinical and Community Issues in Primary Care: Cross-Cultural Issues in Primary Care Module*, US Department of Health and Human Services. Available at: https://med.over.net/javne_datoteke/novice/datoteke/312-readingcyonahcusgovculture1.pdf. [Last accessed 18 February 2017.] The ethnographic material on the Peyote Ceremony gathered during this research has been used in the training module to challenge clinicians to see beyond their ethnocentrism and provide culturally appropriate care to Native American patients. However, there has been no rethinking of peyote's Schedule I status (designating a dangerous drug of abuse with no known therapeutic uses).

[36] K. Ura, S. Alkire, T. Zangmo, & K. Wangdi (2012), *An Extensive Analysis of GNH Index* (Thimphu, Bhutan: The Centre for Bhutan Studies). Available at: http://www.grossnationalhappiness.com/wp-content/uploads/2012/10/An%20Extensive%20Analysis%20of%20GNH%20Index.pdf. [Last accessed 5 September 2017.]

[37] See World Health Organization and Ministry of Health, Thimphu, Bhutan (2007), *WHO-AIMS Report on Mental Health System in Bhutan*. Available at: http://www.who.int/mental_health/evidence/bhutan_who_aims_report.pdf. [Last accessed 5 September 2017.]

little psychotherapy of any kind exists. The system relies heavily on medication, with some psycho-education for detoxing drug and alcohol patients. Modern mental health practices did not previously exist in Bhutan. Until then, communities had relied solely on traditional forms of treatment for problems that developed nations would have described as mental illness. These were mainly *pujas*, which are rituals led by Buddhist monks or shamans.

The author's research was undertaken over four summers spent mainly in the capital city of Thimphu, combining volunteer clinical practice as a psychologist with anthropological fieldwork on local understandings of mental illness. Bhutan is undergoing a high level of rural to urban migration, which is changing patterns of work, gender roles and illness. With its growth, Thimphu is experiencing many new problems, such as disruptive youth and significant alcohol and substance abuse problems. Patients with psychiatric disorders are also referred to Thimphu from regions throughout the country, so there is a very diverse patient mix to observe. Initial research questions were very broad: Are the understandings of psychiatric illness developed in the West valid for Bhutan, a geographically isolated country in which cultural influences from other countries have been rigidly controlled? Or is the local situation completely unique (as relativist anthropologists would tend to assume)? Do Bhutanese patients respond to standard psychological and psychiatric treatments? Or are standard approaches completely irrelevant? An investigation into the effects of healing ceremonies and traditional medicine (*Sowa Rigpa*) was considered necessary to test whether there were healing practices already in place that might be useful and effective.

This case study indicated that the same sorts of psychiatric illnesses that are found around the world occur in Bhutan, though they are often interpreted as spiritual afflictions.[38] Mental illness is most often explained in terms of spirit possession, being punished or attacked by a spirit or deity or, ultimately, as due to karma (the effect of something one did in a previous existence). However, regardless of the local interpretations, there were many classic presentations of familiar disorders. Even though the population has not been 'indoctrinated' into modern psychiatric interpretive frameworks, the author's research and clinical practice reveal that clearly identifiable cases of depression, suicide, psychotic disorders, panic disorders, OCD, epilepsy, developmental disabilities, alcoholism and substance misuse are found throughout the country.

[38] Calabrese, J. D. & Dorji, C. (2014), Traditional and Modern Understandings of Mental Illness in Bhutan: Preserving the Benefits of Each to Support Gross National Happiness, *Journal of Bhutan Studies*, 30, pp. 1-29.

Patient case study

The author treated a young man from a relatively isolated area of Western Bhutan. Initially, he complained of distressing thoughts causing pain inside his body, making him weak. In a later therapy session, he admitted to rumination if he had negative thoughts about another person. When he saw friends smoking, chewing *doma* (betel and areca), or acting in a way of which he disapproved, he had negative thoughts about them. He obsessed about these negative thoughts and felt that he had to neutralise them. Thus, when he had the thought, "That's a negative person, not acting true to their cultural values," he tried to neutralise this thought by pairing this person with a positive person in his mind. He often ordered a group of people in his mind as follows: Bad person - good person - bad person - good person (so that each bad person was paired with a good person to expunge the anxiety-provoking 'badness'). This is a clear case of Obsessive Compulsive Disorder (OCD) with a mental ritual; classic symptoms, despite occurring in a relatively isolated population within Bhutan with little knowledge of modern psychiatry. It would appear that such a pattern of behaviour (which was distressing to the patient) is not simply a construct of the West, but rather much more general to the human condition.

Many other classic presentations were witnessed, including the tragic case of a man with psychosis who, responding to command auditory hallucinations, stabbed his wife to death. There were some differences observed in this context, such as more episodes of brief remitting psychosis encountered at the hospital than chronic schizophrenia. However, that was a possible by-product of higher death rates for Bhutanese with schizophrenia, or of home confinement (including chaining) of more disturbed individuals as sometimes practised in Bhutan, which is often encountered when an inadequate mental health system is in place. The Bhutanese chief psychiatrist's opinion was that traditional treatment was ineffective in treating severe mental disorders such as schizophrenia.[39]

In terms of treatments, patients generally responded as expected to modern psychiatric drugs and to psychotherapy,[40] even when the illness seemed very 'spiritual' to them. This depended on patient engagement and the quality of the medications that were available. It is noteworthy that in Bhutan at times there can be substandard or otherwise ineffective batches

[39] Personal communication expressed to the author during research. The doctor had qualified in psychiatry in Sri Lanka and India.

[40] This is taking into account the individual differences in insight, motivation and responsiveness to treatment that are typically encountered when treating mental illness in any context.

of medicine. This became very apparent when several patients with mania were on the ward and none were calming after several weeks of treatment with a mood stabilising medication.

Upon analysis, there was some level of local knowledge of the psychopharmacological properties of plants in Bhutan. The author investigated the composition of seven Bhutanese *Sowa Rigpa* medicines associated with the treatment of mental illness symptoms. Six of the seven contain *Myristica fragrans* and five contain *Aquillaria agallocha*.[41] *Myristica fragrans* (nutmeg) is psychoactive in high doses because it contains myristicin, which, like some antidepressant medications, is a monoamine oxidase inhibitor. *Aquillaria agallocha* has been found to contain a central nervous system depressant. However, a modern psychiatric practitioner would find the availability of only a weak monoamine oxidase inhibitor and a general central nervous system depressant for the treatment of all psychiatric illness very limiting. Nothing was witnessed to indicate that traditional ritual interventions or local medicines were effective for severe mental disorders like psychoses. Instead, many patients went through years of ritual treatments that were ineffective and, when finally brought to the hospital after all else had failed, were either catatonic or had developed a treatment-resistant chronic mental illness. Such catatonia was then effectively treated by psychotropic medicine and symptoms of severe mental illness were often, though not always, ameliorated.

The evidence pertaining to this clinical ethnographic study of Bhutan does not support a relativist argument, but instead one for species-wide patterns of severe mental illness and the need for a greater availability of modern treatment approaches, including not only authentic and potent medicines, but also psychotherapy and psychosocial rehabilitation (which are more focused on increasing social functionality than on simply eliminating symptoms).[42] As the chief psychiatrist stated, acceptance of modern medical approaches, particularly in relation to psychiatric treatment, is a huge challenge in a society like Bhutan, where most people are used to traditional forms of treatment.[43]

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[41] Calabrese & Dorji (2014), *op cit.*, nt.38, pp.15-17. The author of this chapter analysed data on ingredients and uses of various medicines listed by the Institute of Traditional Medical Services in Bhutan.

[42] See Farkas M. & Anthony, W. A. (2010), Psychiatric rehabilitation interventions: a review, *International Review of Psychiatry*, 22, pp.114-29; McGurk, S. R., Twamley, E. W., Sitzer, D. I., *et al* (2007), A meta-analysis of cognitive remediation in schizophrenia, *American Journal of Psychiatry*, 164, pp.1791-1802; Mueser, K., Corrigan, P. W., Hilton, D. W., *et al* (2002), Illness management and recovery: a review of the research, *Psychiatric Services*, 53(10), pp.1272-1284; Durham, R. C, Guthrie, M., Morton, R. V., *et al* (2003), Tayside-Fife clinical trial of cognitive-behavioural therapy for medication-resistant psychotic symptoms: Results to 3-month follow-up, *The British Journal of Psychiatry*, 182(4), pp.303-311.

[43] Personal communication expressed to the author during research.

However, Bhutan does have valuable cultural resources for mental well-being. The spiritually-motivated practice of compassion and kindness in Bhutan, along with the interpretation of life in terms of karma, results in a generally very sane and peaceful society. Bhutan's violent crime rate is relatively low. Stray dogs and cows nap in the middle of busy streets, since drivers will avoid the bad karma that would result from hitting them. Even taxis will sound their horn and slow down to avoid hitting a pigeon. Human and animal life is seen as more valuable there than in many other places globally. This way of valuing life and prioritising compassion, whilst not eliminating the reality of severe mental illness, is an important resource for mental health at a societal level that Bhutan would do well to preserve and perhaps integrate more explicitly into the care of people with mental illnesses. Furthermore, other states seeking to meet SDG3 could learn from this value-system.

Conclusion

The case studies discussed above indicate that, when faced with diverse claims about traditional and other culture-based forms of treatment, simplistic relativist arguments and blanket policies that encourage traditional medicines because they are 'cultural' (or economically expedient) ought to be avoided. Similarly, anti-relativist ethnocentric viewpoints are not always appropriate, since a very effective local intervention may exist. The specifics of the local context matter. As such, a more flexible *meta-relativist* approach is advocated, by which is meant a *relativised* relativism - one that remains open to finding pan-human continuities as well as local particularities.[44] An acceptable form of cultural relativism is the assumption that there can be different, yet equally true, views of the world or approaches to health. For many anthropologists, however, the optimality of the existing local frameworks of meaning and practice is a quasi-religious assumption, often buttressed by extremely questionable theory. When combined with a lack of clinical knowledge and appropriate evaluation, this assumption can miss the actual clinical realities of the local context entirely. Relativism ought not to be an automatic assumption that, when faced with two different worldviews or medical systems, both must be equally valuable. It would be wrong and contrary to achieving SDG3 to refuse to judge a society as failing in terms of mental health provision in comparison to others out of alleged respect for its culture. Local treatments should be assessed in a way that is culturally informed and deeply self-reflective

[44] Calabrese (2013), *op cit.*, nt.19, pp.16 and pp.60-61.

(in terms of questioning potential ethnocentrism), as well as being *clinically* informed and using appropriate empirical methodology. Health effects of local treatments should be assessed objectively, both in terms of the therapeutic effects and the actual or potential anti-therapeutic effects. Promises of effective treatment that do not deliver, but rather impede or delay demonstrably more effective treatments, are anti-therapeutic and should not be supported. Further, approaches that uncritically advocate for them are manifestly unethical.

However, one should always be ready to be surprised by treatment approaches which come from a radically contrasting paradigm, yet still work very well, as in the case of peyote use by Native Americans. Such openness requires an on-going critical examination of personal ethnocentric biases: what part of our understandings and the interventions developed and/or used in our own countries simply derive from our own local cultural convictions and are thus, when imposed on other cultures, manifestations of imperialism? A global 'War on Drugs' (which frequently means indigenous plant medicines that happen to be psychoactive in nature) in the absence of real data that they are dangerous is clearly ethnocentric and imperialist: it is a manifestation of a quasi-religious belief local to Western cultures and energised by the interests of pharmaceutical corporations, for-profit prisons, the political utility of scapegoating cultural others, and a host of other factors to do with neither safety nor efficacy.[45] That said, where an effective medical intervention is introduced to a different culture because there are no effective alternatives, it will not be imperialistic. This is because, despite any treatment flaws (such as side-effects), it is the best intervention empirically demonstrated to help people with a particular form of illness. To meet SDG3, states have a duty to provide the most effective treatments possible and enhance local health care.

Whether a particular mental health intervention works, or is ineffective or dangerous, is an empirical question requiring intensive field research and honest clinical evaluation. It cannot be concluded that, generally, traditional treatments are effective or ineffective. Each case of treatment and each country's heritage, culture and history is different - both in terms of the local interventions involved and the problems treated. The Navajo case study revealed that an indigenous intervention that clashed strongly with Euro-American sensibilities, expectations and understandings of the treatment process is effective treatment for substance

[45] Nutt, D. (2012), *Drugs - Without the Hot Air: Minimising the Harms of Legal and Illegal Drugs* (Cambridge: UIT Cambridge); American Civil Liberties Union (2011), 'Banking on Bondage: Private Prisons and Mass Incarceration'. Available at: https://www.aclu.org/files/assets/bankingonbondage_20111102.pdf. [Last accessed 20 February 2017.]

misuse, and supports general psychological well-being and a harmonious family life.[46] In the context of Bhutan, examining severe mental illness specifically, what stood out were the hundreds of clinical cases inadequately treated with ritual interventions for years, resulting in chronic illness, catatonia, and severely diminished life chances.[47] Nonetheless, a very compassionate and peaceful social milieu appeared to function to support mental health and prosocial behaviour.

Finally, it is unnecessary to choose between a biologically-reductionist, medication-based approach to public psychiatry and group-based relational approaches, which often have the benefit of mobilising local networks of social support. How can local support networks be utilised without at times reinforcing problematic beliefs about the nature of illness? Mutual support groups for patients and their communities can be extremely valuable when their ideologies do not undermine effective clinical services.[48] This has been observed in the collective ceremonies used within Native American communities which provide significant support, increase resilience, and aid healing. In addition, group psychotherapy, therapeutic milieu approaches, and psychiatric rehabilitation can be extremely useful in the treatment of mental illness, and their drawbacks are minimal in comparison to the side-effects associated with psychiatric drugs.[49] Individualism, as manifested in the reduction of mental illness to individual biology and the limiting of treatment to one medicated patient at a time, is potentially an aspect of the ethnocentrism of the West that should be critically examined in efforts to promote well-being and meet SDG3 effectively.

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[46] Calabrese (2013), *op cit.*, nt.19, pp.18-23 and pp.139-198.
[47] Calabrese & Dorji (2014), *op cit.*, nt.38.
[48] Corrigan, P. W., Calabrese, J. D., Diwan, S. E., *et al* (2002), Some Recovery Processes in Mutual-Help Groups for Persons with Mental Illness I: Qualitative Analysis of Program Materials and Testimonies, *Community Mental Health Journal*, 38(4), pp.287-301; Pistrang, N., Barker, C. & Humphreys, K. (2008), Mutual Help Groups for Mental Health Problems: A Review of Effectiveness Studies, *American Journal of Community Psychology*, 42(1-2), pp. 110-21.
[49] Calabrese & Corrigan (2005), *op cit.*, nt.5. Also see R. P. Liberman (2008), *Recovery from Disability: Manual of Psychiatric Rehabilitation* (Washington, DC: American Psychiatric Publishing, Inc). For a comprehensive critique of the Western biomedical model in the treatment of psychosocial disability, see the chapter of this book by Peter Lehmann.